UNITED STATES DEPARTMENT OF THE INTERIOR MINERALS MANAGEMENT SERVICE GULF OF MEXICO REGION ACCIDENT INVESTIGATION REPORT

1.	OCCURREI	8.	CAUSE: EQUIPMENT FAILUR
	DATE: 19-MAY-2004 TIME: 0830 HOURS	5	HUMAN ERROR
2	OPERATOR deinghou for longhion		EXTERNAL DAMAGE
۷.	OPERATOR: Spinnaker Exploration Company, L.L.C.		SLIP/TRIP/FALL
			WEATHER RELATED
	REPRESENTATIVE: Ben Benson		LEAK
	TELEPHONE: (985) 781-0804		UPSET H20 TREATIN
3.	LEASE: G23193		OVERBOARD DRILLING FLUID
	AREA: HI LATITUDE: 29.45619221		X OTHER Human Error
	BLOCK: 47 LONGITUDE:- 93.892129 3	879.	WATER DEPTH: 38 FT.
4.	PLATFORM: A	10.	DISTANCE FROM SHORE 15 MI.
		11.	WIND DIRECTION: NE
	RIG NAME		SPEED: 12 M.P.H.
5.	ACTIVITY: EXPLORATION(POE)	12.	CURRENT DIRECTION: S
	DEVELOPMENT/PRODUCTION		SPEED: 2 M.P.H.
_	(DOCD/POD)	13.	SEA STATE: 3 FT.
6.	TYPE: X FIRE	14.	PICTURES TAKEN: YES
		15.	STATEMENT TAKEN YES
	BLOWOUT	16.	OPERATOR REPRESENTATIVE/
	COLLISION		SUPERVISOR ON SITE AT TIME OF INCIDEN
	X INJURY NO. 2		Gary Pierce
	FATALITY NO. 0		CITY: Houston STATE: TX
	POLLUTION		TELEPHONE: (713) 759-1770
	OTHER		
7.	OPERATION X PRODUCTION		CONTRACTOR:
	DRILLINC		
	WORKOVER		CONTRACTOR REPRESENTATIVE/
	COMPLETION		SUPERVISOR ON SITE AT TIME OF INCIDEN
	MOTOR VESSEL		CITY: STATE:
	PIPELINE SEGMENT NO		TELEPHONE
	□ □ OTHER		

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17. DESCRIBE IN SEQUENCE HOW ACCIDENT HAPPE

On Wednesday, May 19, 2004, at about 0735, a fire broke out on Spinnaker's Hig Island (HI) Block 47 A platform. Two contract workers were injured. The Prod foremen works for the Wood Group. The well on this platform has a shut in pres psi and produces with a FTP of psi. The well produces about MMCF/D, bbls of condensate and bbls of water per day. The well also has an H2S component of about ppm, and a content.

The activities at the time of the incident included bleeding down the flow lin removing the hydraulic controlled choke and the choke seat from the choke body SSV located on the tree had been closed from the control panel, allowing for t line and sand knockout to be bled down. No other valves on the tree or flow 1 were closed except those downstream of the choke body to isolate the pressure production equipment. The cap was then removed from the choke body in order to the choke seat. At this time, Byron King apparently mistakenly opened the con switch for the SSV and allowed the full wellhead pressure to flow through the ended choke body. At that instant, Mr., still at the control panel, realized h mistake and then closed the control switch for the SSV. The lag time interval between opening and then closing the SSV with the control switch is esitmated about 20 to 45 seconds depending on his reaction time. In this interval, the well volume was blowing from the open choke body toward the living quarters.

The wind was blowing from the Southeast to the Northwest which allowed the gas to blow over the meter run house and generator house. The Generator is assume the point of ignition of the gas, and it was consumed in the resulting fire al with the adjacent meter run house, meter runs and telemetry. The direction of blast from the open choke body was directly toward the living quarters located 25-30' away from the open choke body, and the living quaarters were rapidly co in the blaze. The contract injured man with the burns worked for E S & H and the living quarters at the time of the incident, while the other contract man for Schooner Chokes sustained the broken bone when he jumped to the lower deck

18. LIST THE PROBABLE CAUSE(S) OF ACCIDENT:

In the instant that Byron King switched open the SSV, he realized his error, an switched to close the SSV. Grasping the magnitude of the fire, Byron King then the well control panel, ran down the adjacent stairs and closed the ESD switch at the lower deck level. The time lag in the activation of the ESD would have h about one and one-half minutes to full closure. The blast of gas out of the or choke body which was about 2 feet above the deck was like a blow torch aimed di toward the living quarters. The living quarters were constructed of aluminum, a and its contents were completely destroyed along with the adjacent 2-300 gallon plastic fresh water tank next to the living quarters. No dry chemical system, water system or safety shut down sysem could have saved the living quarters or anything else within the blast flame direction from the choke body within the c time of the SSV. The 150 pound dry chemical wheeled unit adjacent to the livin quarters would not have slowed the blaze. There was no fire wall or shield (su an A-60 barrier) located between the choke manifold, production equipment, mete and the living quarters.

19. LIST THE CONTRIBUTING CAUSE(S) OF ACCIDENT:

The main cause of the fire appears to be the inadvertent opening of the SSV at

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20. LIST THE ADDITIONAL INFORMATION:

There is no fired equipment on this platform. From the wellhead, the gas trave through the sand knockout to the choke manifold at full wellhead pressure Afte pressure cut at the choke, it then goes through the fin-fan unit to cool ahead separator. It is then separated, measured and delivered to the pipeline. The condensate is measured separately and returned to the wet pipeline. The genera and living quarters can be considered the only sources of ignition. The well on platform has a shut in pressure of psi and produces with a FTP of psi. The well produces about MMCF/D, bbls of condensate and bbls of water per day. The well also has a H2S component of about ppm, and a content. There was no pollution.

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21. PROPERTY DAMAGED

NATURE OF DAMAGE:

The major items destroyed in the fire Fire burned, damaged or destroyed were the living quarters building with its contents, the meter run house, met runs and telemetry systems, and the magenerator. There appeaars to be no strucdtural damage; only smoke and pai damage.

ESTIMATED AMOUNT (TOTAL) \$800,000

22. RECOMMENDATIONS TO PREVENT RECURRANCE NARRATI

The Lake Jackson District has no recommendation for MMS.

The following are the recommendations made to the operator by the Lake Jacksc District office:

A. Require a list of values on the tree and production equipment to be manual closed prior to any pressure bleed down for any piece of equipment to be remc repaired or replaced. These values would be in addition to closing of any automatic value that might be opened or closed from the control panel. There no automatic control shut-down value on the swab value line to the sand knock or the sandknock out itself. There apparently were not any safety control pi or controls on the swab line or sand knockout.

B. Change the location of the choke manifold to the lower deck, or to the edg the platform so that any escaping gas would naturally be directed away from t living quarters building, generator and/or platform.

C. Disconnect the existing flow line from the swab valve to the sand knockout install this line to either wing of the tree which would allow another level pressure control. This would allow the proper use of the swab valve to be us a swab valve with available bottom hole connection.

D. Provide a fire wall or shield (such as an A-60 barrier) between all of the production equipment and the living quarters. Remove and isolate all flammak equiupment and material away from the living quarters.

23. POSSIBLE OCS VIOLATIONS RELATED TO ACCIDEYES

24. SPECIFY VIOLATIONS DIRECTLY OR INDIRECTLY CONTRIBUTING. NARR

The addition of the flow line from the swab valve to the sand knockout, and t sand knock itself are not described the current approved process flow diagram safe chart at the time of the fire. There appears to be no safety shut down devices on the sand knockout or swab flow line.

The flow line from the sand knockout to the choke manifold was installed with screwed fittings and hammer unions. There was no approval for this installat for the use of 2-inch piping with screwed fittion at wellhead pressures at th of the fire.

	25.	DATE (OF	ONSITE	INVESTIGATI	28.	ACCIDENT	CLASSIFICATIO
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21-MAY-2004

26. ONSITE TEAM MEMBERS: 29. ACCIDENT INVESTIGATI Harry J. FitzGibbon / PANEL FORMED: NO

OCS REPORT

27. OPERATOR REPORT ON FILE

30. DISTRICT SUPERVISOR

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Pausina for Smith

APPROVEI DATE: **10-AUG-2004**

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FIRE/EXPLOSION ATTACHMENT

1. SOURCE OF IGNITION Natural gas released from open choke body.

2.	TYPE	OF	FUEL:	x	GAS
					OIL
					DIESEL
					CONDENSATE
					HYDRAULIC
					OTHER

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3. FUEL SOURCE: Gas well

4. Were precautions or actions taken to isolate known sources of ignition prior to the accide ${\bf NO}$

5.	TYPE	OF	FIREFIGHTING	EQUIPMENT	UTILI2	HANDHELD
						WHEELED UNIT
						FIXED CHEMICAI
						FIXED WATER
					x	NONE
						OTHER

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INJURY/FATALITY/WITNESS ATTACHMENT

	ESENTATIVE	X INJURY	
X CONTRACTOR RE		FATALITY	
NAME :			
HOME ADDRESS:			
CITY:		STATE:	
WORK PHONE:	ТО	TAL OFFSHORE EXPERIENCE	
		lth & Safety, / 21590	
BUSINESS ADDRESS			
CITY: ZIP CODE:	Houma	STATE: LA	
	70360		
OPERATOR REPR	PRESENTATIV		
X CONTRACTOR RE		- FATALITY	
X CONTRACTOR RE	PRESENTATIV	- FATALITY	
X CONTRACTOR RE	PRESENTATIV	- FATALITY	
X CONTRACTOR RE OTHER	PRESENTATIV	- FATALITY	
X CONTRACTOR RE OTHER NAME: HOME ADDRESS:	PRESENTATIV	FATALITY	
X CONTRACTOR RE OTHER NAME: HOME ADDRESS: CITY: WORK PHONE:	PRESENTATIV	FATALITY WITNESS STATE:	
X CONTRACTOR RE OTHER NAME: HOME ADDRESS: CITY: WORK PHONE:	PRESENTATIV TO Chooner Petroleu	FATALITY WITNESS STATE: TAL OFFSHORE EXPERIENCE n Services, I : / 21588	
X CONTRACTOR RE OTHER NAME: HOME ADDRESS: CITY: WORK PHONE: EMPLOYED BY: SC	PRESENTATIV TO Chooner Petroleu	FATALITY WITNESS STATE: TAL OFFSHORE EXPERIENCE n Services, I : / 21588	

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